BP-A612_APPLICATION FOR APPOINTMENT AS A MID-LEVEL PRACTIONER (MLP)

BP-A612.063
JUL 99

APPLICATION FOR APPOINTMENT AS A MID-LEVEL PRACTIONER (MLP)

U.S. DEPARTMENT OF JUSTICE FEDERAL BUREAU OF PRISONS

HEALTHCARE FACILITY			LOCATION			DATE
IDENTIFYING INFORMATION	LAST NAME	FIRST NAME	INITIAL	BIRTHPLACE		DATE OF BIRTH
	OFFICE ADDRESS	CITY	STATE	ZIP CODE	AREA CODE	TELEPHONE
	HOME ADDRESS	CITY	STATE	ZIP CODE	AREA CODE	TELEPHONE
	CITIZENSHIP			SOCIAL SECURITY NUMBER		
	PRACTICE LIMITED TO					
	OTHER MEDICAL INTERESTS IN PRACTICE, RESEARCH, ETC.					
	PRACTICING WITH WHOM AND NATURE OF AFFILIATION					
PREMEDICAL EDUCATION	COLLEGE OR UNIVERSITY			DEGREE		
	ADDRESS			DATE OF GRADUATION		
PROFESSIONAL EDUCATION	P.A. , N.P. OR MEDICAL SCHOOL PROGRAM			DEGREE		
	ADDRESS			DATE OF GRADUATION		
INTERNSHIP	HOSPITAL	ADDRESS				
	ADDRESS			DATES		
RESIDENCES AND FELLOWSHIPS						
	ADDRESS OF INSTITUTION, SPECIALTY AND DATES					

LOCAL REPRODUCTION AUTHORIZED

PROFESSIONAL EXPERIENCE	LIST ALL PRESENT AND PREVIOUS PROFESSIONAL EXPERIENCE, IN CHRONOLOGICAL ORDER		
	NAME AND LOCATION OF HOSPITAL/ORGANIZATION	POSITION	DATES
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BIBLIOGRAPHY	ON SEPARATE SHEET, FURNISH A LIST OF SCIENTIFIC PAPERS OR ESSAYS YOU HAVE WRITTEN, AND A LIST OF SCIENTIFIC MEETINGS YOU HAVE ATTENDED DURING PREVIOUS THREE YEARS (INCLUDE REPRINTS).		
MEMBERSHIP IN PROFESSIONAL SOCIETIES			
SPECIALTY BOARDS AND DATES			
CONTINUING MEDICAL EDUCATION	ON SEPARATE SHEET, LIST ALL POSTGRADUATE ACTIVITIES WHICH YOU HAVE ATTENDED, OR FOR WHICH YOU HAVE RECEIVED CREDIT IN THE PAST TWO YEARS.		

LICENSE	TYPE, NAME OF STATE AND COUNTY	DATE	LICENSE NO.
	TYPE, NAME OF STATE AND COUNTY	DATE	LICENSE NO.
	TYPE, NAME OF STATE AND COUNTY	DATE	LICENSE NO.

PROFESSIONAL REFERENCES	IF POSSIBLE, PROVIDE AT LEAST THE NAMES OF TWO MEMBERS OF THE MEDICAL STAFF AT YOUR CURRENT HOSPITAL OR THE HOSPITAL YOU WERE MOST RECENTLY ASSOCIATED WITH. (NOTE: REFERENCES WILL BE EVALUATED PRIMARILY BY THE EXTENT OF OBSERVATION OF CLINICAL SKILLS AND INTERACTION WITH THE APPLICANT.)	
	NAME	ADDRESS
	NAME	ADDRESS
	NAME	ADDRESS
	NAME	ADDRESS

IF ANSWER TO ANY OF THE FOLLOWING THREE QUESTIONS IS "YES", PLEASE GIVE FULL DETAILS ON SEPARATE SHEET OR PAPER.

A. Has your license to practice medicine in any jurisdiction ever been limited,suspended or revoked? ☐ Yes ☐ No

B. Have your privileges at any hospital ever been suspended, modified, diminished, revoked or not renewed? ☐ Yes ☐ No

C. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any medical organization? ☐ Yes ☐ No

D. Have judgements or settlements in professional liability cases been made against you, or are there any pending? If "Yes", give details on separate sheet of paper. ☐ Yes ☐ No

LIABILITY INSURANCE FO R CONTRACT MLP'S BOP MLP'S WITH APPROVED PRIVATE EMPLOYMENT OR NEWLY	AMOUNT OF COVERAGE	INSURANCE CARRIER	EXPIRATION DATE
	POLICY NO.	AGENT	

I HEREBY APPLY FOR APPOINTMENT	☐ MID-LEVEL PROVIDER IN THE BOP
	☐ OTHER (SPECIFY)

REQUEST FOR MEDICAL PRIVILEGES

FEDERAL BUREAU OF PRISONS

PROVIDERS NAME	INSTITUTION LOCATION	TYPE OF APPLICATION

Privileges to practice medicine in the Bureau of Prisons are granted based on clinical specialty and specific procedure. MLP's may perform procedures or treatments not specifically granted when:

1. The procedure or treatment is closely related technically or by body system to a granted privilege of the provider, or:

2. The provider has documented training and current competency allowing reasonable clinical competence for the procedure or treatment.

MLP's will be granted privileges on initial employment and renewed every year after initial employment.

TYPE OF CARE	Special Limitations	REQUEST	APPROVE
GENERAL CLINICAL CARE Perform & record complete medical history & physical exam, including inpatient admission	Review & counter signature - physician	☐ YES	☐ NO
Examine, prescribe & treat patients presenting on sick call	Within limits of authorized privileges	☐ YES	☐ NO
Indicate diagnostic impression		☐ YES	☐ NO
PARENTERAL THERAPY Prescribe & perform venipuncture to obtain blood specimen		☐ YES	☐ NO
Prescribe & perform venipuncture to start therapy including blood & blood products	Prescribe - emergencies ONLY	☐ YES	☐ NO
TEST & SPECIAL EXAMINATIONS Prescribe & perform lab, ECG, & x-ray procedures done in this institution except those requiring injection of radiopaque material		☐ YES	☐ NO
PHYSICAL THERAPY Prescribe, perform & supervise all PT modalities available here		☐ YES	☐ NO
DENTAL Extractions	Assist dentist ONLY	☐ YES	☐ NO
Fractures	Assist dentist ONLY	☐ YES	☐ NO
Dislocations		☐ YES	☐ NO
Infections & abscess		☐ YES	☐ NO
Post op hemorrhage		☐ YES	☐ NO
Pain		☐ YES	☐ NO
Temporary Fillings		☐ YES	☐ NO
SURGICAL PROCEDURES Close fascia & skin during surgery	Under MD supervision	☐ YES	☐ NO
Close minor lacerations if no nerve, tendon, or artery involvement		☐ YES	☐ NO
Minor surgical procedures such as I&D abscess (culture spec. to lab)		☐ YES	☐ NO
Removal/repair ingrown toenail (all tissue specimen to lab)	After MD consultation	☐ YES	☐ NO

Examine, prescribe, & treat patient during a medical/surgical emergency until MD arrives	Life & death or severe injury	☐ YES ☐ NO
Administer topical, local & simple digit nerve block anesthesia		☐ YES ☐ NO
Admit patients to appropriate service unit	During absence of MD	☐ YES ☐ NO
Order orthopedic braces & appliances at request of primary physician	Countersign written orders for P.A. trainees as individually privileged	☐ YES ☐ NO
Countersign written orders for P.A. trainees as individually privileged		☐ YES ☐ NO
Females - Breast, full pelvic and rectal exam		☐ YES ☐ NO
OTHER (specify and/or draw through unused lines)		☐ YES ☐ NO

MEDICATIONS (Specify limitations, if any, and draw lines through unused lines)	May Order	May Reorder
A. DEA CONTROLLED SUBSTANCES (All require at least Counter-signature by physician)	☐ YES ☐ NO	☐ YES ☐ NO
<u>Schedule II - Narcotic/Non-Narcotic</u>		
2. Meperidine	☐ YES ☐ NO	☐ YES ☐ NO
3. Oxycodone (Percocet)	☐ YES ☐ NO	☐ YES ☐ NO
4. Methadone	☐ YES ☐ NO	☐ YES ☐ NO
5.	☐ YES ☐ NO	☐ YES ☐ NO
6.	☐ YES ☐ NO	☐ YES ☐ NO
7.	☐ YES ☐ NO	☐ YES ☐ NO
<u>Schedule III - Narcotic/Non-Narcotic</u>	☐ YES ☐ NO	☐ YES ☐ NO
1. Acetaminophen with Codeine		
2.	☐ YES ☐ NO	☐ YES ☐ NO
3.	☐ YES ☐ NO	☐ YES ☐ NO
4.	☐ YES ☐ NO	☐ YES ☐ NO
Schedule IV - Narcotic/Non-Narcotic	☐ YES ☐ NO	☐ YES ☐ NO
1. Chloral Hydrate		
2. Diazepam: x 3 days	☐ YES ☐ NO	☐ YES ☐ NO
3. Propoxphene (Darvon)	☐ YES ☐ NO	☐ YES ☐ NO
4. Phenobarbital	☐ YES ☐ NO	☐ YES ☐ NO
5. Nalorphine: in emergency only while awaiting physician	☐ YES ☐ NO	☐ YES ☐ NO
6.	☐ YES ☐ NO	☐ YES ☐ NO
7.	☐ YES ☐ NO	☐ YES ☐ NO
8.	☐ YES ☐ NO	☐ YES ☐ NO
9.	☐ YES ☐ NO	☐ YES ☐ NO
10.	☐ YES ☐ NO	☐ YES ☐ NO

Schedule V - Narcotic/Non Narcotic 1.	☐ YES ☐ NO	☐ YES ☐ NO
2.	☐ YES ☐ NO	☐ YES ☐ NO
3.	☐ YES ☐ NO	☐ YES ☐ NO
B.PSYCHOTROPIC DRUGS - Not DEA Controlled (All Require at least Countersignature by Physician) 1. Amitriptyline	☐ YES ☐ NO	☐ YES ☐ NO
2. Chlorpromazine (Thorazine)	☐ YES ☐ NO	☐ YES ☐ NO
3. Doxepin (Sinequan)	☐ YES ☐ NO	☐ YES ☐ NO
4. Perphenazine (Trilafon)	☐ YES ☐ NO	☐ YES ☐ NO
5. Prochlorperazine (Compazine)	☐ YES ☐ NO	☐ YES ☐ NO
6. Promothazine (Phenegran)	☐ YES ☐ NO	☐ YES ☐ NO
7. Thioridazine (Mellaril): x 3 days	☐ YES ☐ NO	☐ YES ☐ NO
8. Trifuoperazine (Stelazine)	☐ YES ☐ NO	☐ YES ☐ NO
9. Fluphenazine HCl (Prolixin) (Oral and Injection)	☐ YES ☐ NO	☐ YES ☐ NO
10. Haloperidol (Haldol)	☐ YES ☐ NO	☐ YES ☐ NO
11. Amoxapine	☐ YES ☐ NO	☐ YES ☐ NO
12. Bupropion	☐ YES ☐ NO	☐ YES ☐ NO
13. Clomipramine	☐ YES ☐ NO	☐ YES ☐ NO
14. Desipramine	☐ YES ☐ NO	☐ YES ☐ NO
15. Fluoxetine	☐ YES ☐ NO	☐ YES ☐ NO
16. Imipramine	☐ YES ☐ NO	☐ YES ☐ NO
17. Nortriptyline	☐ YES ☐ NO	☐ YES ☐ NO
18. Praspetine	☐ YES ☐ NO	☐ YES ☐ NO
19. Sertraline	☐ YES ☐ NO	☐ YES ☐ NO
20. Trazodone	☐ YES ☐ NO	☐ YES ☐ NO
21. Venlafaxine	☐ YES ☐ NO	☐ YES ☐ NO
22. Loxapine	☐ YES ☐ NO	☐ YES ☐ NO
23. Risperidone	☐ YES ☐ NO	☐ YES ☐ NO
24. Thiothixene	☐ YES ☐ NO	☐ YES ☐ NO
C. DRUGS REQUIRING SPECIAL AUTHORIZATION 1. Anticoagulants (Specify, i.e. Coumadin, Heparin) a. b.	☐ YES ☐ NO	☐ YES ☐ NO
2. Antibiotics/Anti-infectives (Specify) a. b. c. d.	☐ YES ☐ NO	☐ YES ☐ NO
3. Conticorsteroids	☐ YES ☐ NO	☐ YES ☐ NO
4. Digitalis Glycosides	☐ YES ☐ NO	☐ YES ☐ NO
5. Insulin	☐ YES ☐ NO	☐ YES ☐ NO
6. Oral Hypoglycemics: a. Glyburide	☐ YES ☐ NO	☐ YES ☐ NO
b. Metformin	☐ YES ☐ NO	☐ YES ☐ NO

c.	☐ YES ☐ NO	☐ YES ☐ NO
7. Anticonvulsants: a. Primidone (Mysoline)	☐ YES ☐ NO	☐ YES ☐ NO
b. Phenytoin Sodium (Dilantin)	☐ YES ☐ NO	☐ YES ☐ NO
c. Other	☐ YES ☐ NO	☐ YES ☐ NO
9. Anti-inflammatory Agents (specify, i.e., Indomethacin, etc.)	☐ YES ☐ NO	☐ YES ☐ NO
10. Miscellaneous Agents (such as injectable Anti-Hypertensives, etc.) Specify	☐ YES ☐ NO	☐ YES ☐ NO
D. OTHER (Specify)	☐ YES ☐ NO	☐ YES ☐ NO
Administer medications from the pharmacy. Has completed the BOP Pharmacy Training Program.	☐ YES ☐ NO	☐ YES ☐ NO
May prescribe all other formulary medication, except those listed below:	☐ YES ☐ NO	☐ YES ☐ NO

RESTRICTIONS (as determined by policy and the Clinical Director)

SPECIAL PROCEDURES ☐ Approved ☐ Disapproved ☐ Initial

Please list the special procedures for which you are requesting privileges. Attach documentation indicating your qualifications for the procedure(s) requested. Your institution must be able to provide technical support for your request.

Special Studies/Invasive (example: arterial puncture, flexible sigmoidoscopy, spinal tap)

Special Studies/Non-Invasive (example: ECG Interpretation, Ultrasound, exercise treadmill testing)

Outpatient Surgical Procedures (specify) ☐ Approved ☐ Disapproved ☐ Initial

I certify that, to the best of my knowledge and belief, all of the information associated with my request for privileges is true, correct, complete and made in good faith.

Applicant Signature: _____ Date: _____

DEPARTMENTAL/INSTITUTIONAL RECOMMENDATION (FOR STAFF MID-LEVEL PROVIDERS)

- ☐ Recommended for privileges as requested
- ☐ Recommended for privileges with attached modification
- ☐ Recommended for deferral of privileges this time

_____ _____

Clinical Director / Department Chair Date

_____ _____

Acknowledged by Warden / Governing Body Representive Date